ATTACHMENT 2
Sample Prior Authorization Request/Hearing Instrument and Audiological Services (PA/HIAS2) Form

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11021 (Rev. 06/04)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST / HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the PA/HIAS2 Completion Instructions (HCF 11021A).

SECTION I — PROVIDER INFORMATION

1. Name — Provider	4. Address — Provider (Street, City, State, Zip Code)
2. Wisconsin Medicaid Provider Number	
3. Telephone Number — Provider	

SECTION II — RECIPIENT INFORMATION

5. Name — Recipient (Last, First, Middle Initial)	6. Date of Birth — Recipient	7. Telephone Number — Recipient
8. Recipient Medicaid Identification Number	9. Sex — Recipient ❑ Male ❑ Female	10. Has the Recipient Ever Used a Hearing Instrument? ❑ Yes ❑ No
11. Describe Prior Hearing Instrument Use	12. Testing Date	13. Test Reliability (check one) ❑ Good ❑ Fair ❑ Poor

SECTION III — DOCUMENTATION

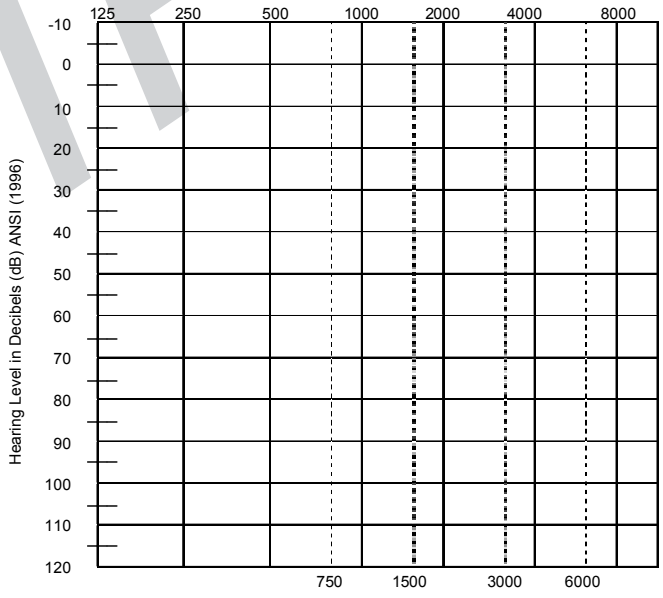
14.

Legend

Ear	Air: Un masked	Air: Masked	Bone: Un masked	Bone: Masked	NR
Right	o - o	Δ – Δ	<	[	↙
Left	x - x	□ – □	>	]	↘

SPEECH AUDIOMETRY	R	L	SF
Threshold (SRT or SDT)			
Word recognition in quiet			
Word recognition in noise			
Uncomfortable level (dB-HL)			
Most comfortable level (dB-HL)			

15. Pure Tone Audiogram — Frequency in Hertz (Hz)



16. Additional Audiometric Studies and Results, Pertinent Social Background, Other Relevant Information (use an attachment if necessary)

17. Recommendations for a Hearing Instrument (use an attachment if necessary)

Ear (check one) ❑ Left ❑ Right ❑ Both

Ear Mold Style_____ Hearing Aid Style_____

Describe Electroacoustic Specifications

Ear Mold ❑ Left ❑ Right ❑ Both

Special Modifications

18. **SIGNATURE** — Requesting Provider	19. Name — Requesting Provider (Print)	20. Provider Type (check one): ❑ Audiologist ❑ Hearing Instrument Specialist	21. Date Signed